Year 2006

HIV Prevention Plan Update for Hawai`i

September 2005

Hawai`i HIV/AIDS
Community Planning Group

Hawai`i Department of Health

2006 HIV Prevention Plan for Hawai`i - Update

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I. Executive Summary

This Plan Update represents the recommendations and plans for HIV Prevention for the state of Hawai`i for the calendar year 2006. This plan is an update of the 2004 and 2005 Plan documents. This document describes the recommendations made and approved by the Hawai`i HIV Prevention Planning Group (CPG) in the calendar year 2004 and the first two months of 2005.

The most significant and major recommended change made by the CPG is the *re-prioritization of interventions and strategies* for each of the six previously prioritized populations at risk in the state. This new prioritization was based on a variety of data. The CPG was involved in collecting and examining these data for a period of six months. All recommendations for this re-prioritization were based on this thorough, lengthy process. Details of the new priorities for interventions can be found on pp. 6.

Based on the results of the re-prioritization, SAPB staff have provided training to the community related to evidence-based interventions and have included "EBIs" in the RFPs to Community Based Organizations for 2006.

Since the CPG has previously prioritized HIV-positive individuals as the primary target group for prevention activities, the Hawai`i "Prevention for Positives" or "P4P" program has been maintained and expanded throughout the state.

A CPG directed Needs Assessment for the transgender risk group was completed in late 2004. Data from this research effort was used in the re-prioritization process.

SAPB staff are significantly involved in beginning the PEMS system and have kept the CPG up to date on progress with this complex data collection and evaluation program.

II. CPG Process

A. Introduction: A New Planning Model

A very major change was instituted in the CPG organization itself. A new model for community planning that includes both the prevention and care areas was instituted in March 2005 after a lengthy and participatory planning process. The primary purpose for this new planning model was to improve the continuity of care for those at risk for, affected by, and infected with HIV in the state. A planning task force was created in May 2004. The ten members of this task force were volunteers equally divided from the prevention CPG and the care planning group, *Hawai`i* CARES. SAPB staff facilitated the task force. The group selected a name for itself: ***Kakou***, a Hawaiian word meaning "We, Together." Kakou was charged by the SAPB to come up with recommendations concerning the mission, goals, objectives, organizational structure, membership eligibility, member recruitment methods, and basic implementation steps to create a collaborative community planning process for both care and prevention services in Hawai`i. Kakou met six times from June-September, 2004. Kakou was able to meet all the charges of SAPB in that timeframe.

B. Recruitment of Members

Both the existing planning groups for prevention and for care were dissolved at the end of 2004. Members of those groups were encouraged to apply for the new group, which would be named the *Hawai`i HIV/AIDS Community Planning Group.* In addition, members were encouraged to recruit new candidates and the SAPB ran print notices in gay-oriented magazine, other print venues, and through comprehensive E-mail databases. A new selection task force was created to review applications and select the 28 members of the new planning group. After a series of meetings in January and February 2005, this task was completed. The new group first met in March 2005 with one of two all day Orientation meetings.

C. Year 2006 CPG Planning Schedule

The basic CPG Planning Calendar for 2006 is provided on the following pages.
There are nine CPG meetings per calendar year.

Year 2006 CPG Planning Schedule

January	**February**	**March**	**April**
CPG meeting	**CPG meeting**	**CPG meeting**	**No CPG meeting**
Election of Community Co-chairs			
Committees:	**Committees:**	**Committees:**	
* Begin mapping out plans for the year	*Annual Strategic Planning and Leadership Meeting (Steering Committee)	* Begin work on committee recommendations for 2007	
	DOH:	**DOH:**	
	* Begin work on 2005 annual progress report	* Continue work on 2005 progress report due to CDC	

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Year 2006 CPG Planning Schedule

May CPG meeting	June CPG meeting	July CPG meeting	August CPG meeting
	*****CPG members to review 2007 Plan Update	***** CPG review budget by July 15 * Self- Evaluation of community planning and CPG (survey) * CPG Approval of the Plan Update	* Review IPR *Determine concurrence or non-concurrence
Committees: ***** Finish recommendations for 2007 to be included in Plan Update	**Committees:** ***** Continue priority projects	**Committees:** ***** Ad hoc Budget committee meets to review proposed Application budget	**Committees:** ***** Continue priority projects
DOH: *****Develop draft of 2007 Prevention Plan	**DOH:** ***** Complete 2006 Prevention Plan * Begin grant application * Begin preparing budget	**DOH:** ***** Recruitment of new members, on-going until election * Continue writing application * Complete federal budget for IPR/ Application	**DOH:** ***** Complete 2005 IPR/application

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September **CPG Meeting** **Committees** *Continue priority projects. **DOH:** * Submit CDC 2006 IPR	**October** No CPG meeting	**November** **CPG meeting** *****Election of new CPG members *End of working year celebration. *****Recognition of members' contributions	**December** No CPG meeting

D. Prioritization of Populations

The CPG prioritized the state of Hawai`i's HIV prevention populations for 2003 and beyond. The goals for these populations reflect this new prioritization. Prioritized populations, in order of their priority status are: (1) HIV+ Persons; (2) Men who have Sex with Men / Injecting Drug Users (MSM/IDUs); (3) Men who have Sex with Men (MSM); (4) Injecting Drug Users (IDUs); (5) Transgenders at Risk; and (6) Women at Risk. *These prioritized groups will continue in 2006.* In addition, sub-populations were identified by the CPG. Note that these sub-populations were not prioritized. The identified sub-populations in alphabetical order are: the homeless, immigrants**,** individuals in the military, individuals in prison or on parole, individuals in rural areas, individuals in urban areas, men who have sex with men and women, the mentally ill, races/ethnicities (Caucasian, Asian, Native Hawaiian, Pacific Islander, African American, Latino/a, and Native American), sex industry workers, substance users, and youth.

The new document for the state of Hawai`i, *Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Planning* was be completed in 2005 by the SAPB Surveillance Department, based on CDC's Guidance. It includes data from 1983-2001, diagnosed and reported to September 2003.

Current AIDS surveillance data include:

- v Various racial/ethnic groups (Caucasian, Latino, African American, Hawaiian, Filipino, Asian/Pacific Islander, Japanese) by risk behaviors
- v Risk factors by ethnicity
- v Risk behavior by gender
- v Ethnicity by gender
- *v* AIDS cases of Hawaiians and non-Hawaiians by age group
- v Counseling and testing data for HIV positive clients

The EPI Profile also includes the following HSPAMM HIV data:

- v Female HIV positive participants by age and race
- v Male HIV positive participants by age and race
- v Male HIV positive participants among Asian and Pacific Islanders by age

The 2005 *Integrated Epidemiologic Profile for HIV/AIDS Prevention and Care Planning* reinforced the findings of previous profiles. MSM continue to be at greatest risk for AIDS, followed by IDU and MSM/IDU. Caucasians comprise most of the cases followed by Asian Pacific Islanders and Latinos. The majority of AIDS cases are found on the most populous island of O`ahu.

In September 2001, HIV reporting commenced in Hawai`i using an unnamed test code (UTC) to ensure confidentiality and reduce perceived barriers to testing and reporting. HIV reporting will provide current data but only for those individuals who are tested. Discussions about changing from UTC to name-based reporting for HIV are currently underway at the STD/AIDS Prevention Branch (SAPB). Name based reporting is thought to be a more efficient method to gather HIV data.

E. Prioritization of Interventions for Priority Populations

In the last half of 2004, the CPG re-prioritized strategies and interventions for each of the six prioritized populations. The re-prioritization was done for the more urbanized island of O`ahu *separately* from the more rural Neighbor Islands: Kauai County (Kauai island), Hawai`i County (the Big Island), and Maui County (Maui, Lanai and Molokai islands). The category for HIV+ persons was further broken down into at-risk sub-groups (MSM/IDU, MSM, IDU, Transgender, and Women.)

The eight (8) strategies and interventions prioritized by the CPG for 2006* are listed below. *Note that these strategies and interventions are not listed in priority order.*

ILI – individual-level intervention
GLI – group-level intervention
OR - outreach
PCM – prevention case management
CTR – counseling, testing, and referral
HC/PI – health communication / public information
CLI – community-level intervention
SEP – sterile syringe exchange program

Hawai`i HIV Community Planning Group (CPG) Prioritization of Interventions, 2004-early 2005

1. HIV+									
HIV+ MSM/IDU		HIV+ MSM		HIV+ IDU		HIV+ TG		HIV+ Women	
Oahu	NI	Oahu | NI		Oahu	NI	Oahu | NI		Oahu | NI	
ILI		ILI		ILI		ILI		ILI	
PCM		GLI		HC/PI	PCM	GLI		GLI	
HC/PI		PCM		PCM	HC/PI	PCM		PCM	
CLI	CLI/GLI	HC/PI		GLI		HC/PI		HC/PI	
GLI		CLI		CLI		CLI		CLI	

2. MSM/IDU	3. MSM	4. IDU		5. TG		6. Women	
Oahu | NI	Oahu | NI	Oahu	NI	Oahu	NI	Oahu	NI
SEP		SEP					
OR	OR	OR		OR		OR	
CTR	CTR	CTR		CTR		CTR	
ILI	ILI	GLI	ILI	GLI	ILI	GLI/ILI	GLI
HC/PI	CLI	ILI	PCM	ILI	GLI		ILI
PCM	GLI	PCM	GLI	CLI		PCM	HC/PI
GLI	HC/PI	HC/PI		HC/PI		HC/PI	CLI
CLI	PCM	CLI		PCM		CLI	PCM

F. CPG Committees

The newly formed CPG chose to establish three standing committees in addition to a Steering Committee. An Ad Hoc By-laws Committee was also established to write the official by-laws that would govern the new group. Except for the Standing Committee, Standing Committees meet at each of the all-day meetings. The standing committees and their charges are:

o Needs Assessment, Community Resources Inventory, Gap Analysis, & Prioritization Committee

This committee determines the advisability of conducting new needs assessments, reviews the data in previous needs assessments for planning. It also takes the lead in coordinating any community resource inventories and gap analyses. It leads the prioritization of at-risk groups and interventions/strategies.

oQuality Assurance (QA) and Evaluation Committee

This committee is currently developing standards for care case management and will, in future, develop recommendations for policies and procedures around care case management, will investigate prevention case management and any evaluation results and data produced by the SAPB through PEMS and the care service evaluation system named Reggie.

oContinuum of Care and Integration Committee

This group looks at opportunities where care and prevention services can be better coordinated or integrated to promote an improved continuum of care from prevention to care. It may identify gaps in service, duplication of services and overlapping areas. After doing its research, the committee will make recommendations to the SAPB for follow-up.

oStanding Committee

The Standing Committee, comprised of the three CPG co-chairs and the chairs of the standing committee, provides overall leadership for the CPG process, develops and annual work plan, conducts meetings, resolves conflicts, assures that the BY-laws are being followed and makes sure that the evaluation of the CPG process is monitored and fed back to members.

Also worth noting here is the:

Counseling and Testing (A Committee from the Former Prevention CPG)

The Counseling and Testing Committee was a standing committee of the former CPG. It consisted of members concerned with HIV counseling/testing services in Hawai`i. This committee met to discuss strategies to increase accessibility to services and to improve the quality of services. In 2004, at the instigation of the CTR Committee, all Counselors and Testers directly employed by or funded by the DOH completed a written survey concerning CTR. The results of this survey were reflected in the recommendations in the Plan Update for 2005. The CTR information below is an update on those recommendations and gives a status report on each recommendation*. The newly formed CPG does not have a committee dedicated to CTR issues at this time.*

Recommendation update:

- Expand statewide promotion of CTR services for targeted populations- on-going in 2006
- Expand partner counseling and referral services (PCRS) training to ALL counselor/testers to improve the quality of the formal PCRS services at DOH and of the informal PCRS at CBO's.
- Develop and implement a monitoring and evaluation protocol to improve the quality of PCRS – database was implemented at Diamond Head Health Center using STD

MIS.

- ❖ Continue integration of CTR services with STD and Hepatitis services, especially on the Neighbor Islands - on-going.

- ❖ Improve accessibility of free gonorrhea and chlamydia screening testing services on neighbor Islands – waiting to implement urine based testing at DOH CT sites.

- ❖ Ensure statewide implementation of Rapid testing (Oraquick) including community based organizations (CBOs)- on hold, pending change of Hawai`i state administrative rules. Rapid testing DOH Guidance was published.

- ❖ Continue to provide counseling/testing training for new counselor/testers at least four time a year or as needed. Increase the number of updated and advanced training for previously trained counselor/testers – to continue.

- ❖ Evaluate and improve current CTR services in prisons and create a statewide-standardized collaboration system- no work accomplished, not a priority for 2006.

- ❖ Develop collaboration with private physicians to 1) increase accessibility to CTR services, referral services for newly diagnosed HIV positive individuals, PCRS, and STD and Hepatitis services, and to 2) monitor the quality of the CTR services private physicians provide – on-going.

- ❖ Strengthen communication between DOH and counselor/testers – on-going.

- ❖ Conduct an evaluation of CTR services including service providers and consumers – on going, integrated into QA monitoring. No funds for a specific evaluation.

- ❖ Conduct consumer research (a survey) to assess the barriers confronting at-risk populations in accessing CTR services statewide, especially in the neighbor islands – informal survey planned in 2006. No funding is available for a formal statewide survey.

G. Community Planning Evaluation Plan

<u>Feedback about individual CPG Meetings:</u>
At the end of each CPG meeting, members are invited to give written feedback about that meeting. A standardized form asks two general questions: a) What did you like about this meeting? and b) What suggestions do you have to make these meetings better? The CPG Coordinator and the Co-chairs review the summarized feedback at Steering Committee Meetings. The written summary of responses is also shared with members at the next meeting. If there are significant areas of negative feedback, those areas are discussed at meetings and improvements sought from the group. This process has been helpful in making changes to improve logistics and processes concerning the CPG meetings.
<u>Feedback about the Community Planning Process</u>:
The CPG also administers the CDC's Community Planning Membership Survey. Until 2004, Hawaii used its own survey. In 2004, Hawaii began to use the CDC's Community Planning Membership Survey and will continue to do so in the future. The CPG Coordinator and Evaluation Specialist present summarized survey results to the CPG.

III. Gap Analysis Process

Hawai`i has been involved in implementing needs assessments since the inception of community planning, with the collaboration and support of the CPG. SAPB staff have been responsible for facilitating and implementing this process, with guidance from the CPG. This process has been accomplished in stages. The SAPB currently has seven completed needs assessment reports that have been developed and used since 1999. These needs assessments have proved to be valuable resources for the CPG in making decisions about the prioritization of populations at-risk for HIV and interventions for these populations. SAPB staff have also developed several resource inventories related to HIV prevention services offered to at-risk groups in Hawai`i, including a periodically produced SAPB directory of agencies providing these services.

As stated in this plan, Hawai`i has had a combined prevention and care CPG since early 2005. One of the priority activities for this newly formed group will be a Community Resource Inventory that reflects Branch and community-based services for both HIV prevention and care. This Community Resource Inventory will be a component of a larger Gap Analysis that will be developed by the combined CPG and will include the current needs assessments and evaluation data and information.

A. Community Resource Inventory

Hawaii's Resource Inventory of HIV prevention activities is composed of diverse interventions currently being provided by community-based organizations (CBOs) and the STD/AIDS Prevention Branch (SAPB). The Resource Inventory also includes several reports and studies funded by the SAPB, on the advice of the CPG. These studies have been implemented within the past two years. The following are the components of Hawaii's Resource Inventory related to HIV prevention service delivery:

 STD/AIDS Prevention Branch – SAPB staff includes individuals working within its seven programs (see Programs Resources below), as well as secretarial and other support staff. Contracted agencies implement HIV prevention interventions such as Prevention for Positives (P4P), Counseling and Testing (C/T), outreach, individual level interventions (ILIs), group level interventions (GLIs), community level interventions (CLIs), prevention case management (PCM), Partner Counseling Referral Services (PCRS), Informal PCRS, Health Communication and Public Information (HC/PI), structural interventions, and community-building interventions. Contracted agencies hire part-time and full time staff, provides stipends to peers, and utilize volunteer services.

 SAPB (Branch) Program Resources – The eight programs of the SAPB are:

< AIDS Surveillance Program,
< Hawai`i Seropositivity and Medical Management Program Services
< (HSPAMM)
< STD/HIV Education and Risk Reduction Services,
< HIV Counseling and Testing Services,
< Prevention For Positives
< STD Diagnosis and Treatment Program,
< Partner Notification and Partner Counseling and Referral Services,
< Viral Hepatitis Prevention Program

Each of these programs has well defined goals and objectives and collaborates with community-based organizations. The programs also have collection and evaluation components, which are

an integral part of the Resource Inventory, (i.e. AIDS Surveillance Quarterly Report, C/T data, STD data, HSPAMM data, etc.).

Community-Based Resources - HIV prevention services are offered to at-risk populations through programs contracted by the SAPB to provide services. HIV services are also offered within the community by the community-based organizations (CBOs) not receiving funding from the SAPB. The status of these HIV prevention programs are presented to the CPG regularly through presentations by individuals who work with at-risk populations, staff of contracted and other community-based agencies, and SAPB staff who present updates on the progress of contracted HIV prevention services statewide, including data collection regarding interventions and client demographics.

The following are the current HIV prevention services provided by community-based organizations, listed by CPG 2004 prioritized populations:

HIV+ Persons
Referrals to treatment services
Outreach
Counseling and Testing
Prevention Case Management
Individual Level Interventions
Partner Counseling and Referral Services

MSM
Community Level Interventions
Individual Level Interventions
Prevention Case Management
Outreach
Counseling and Testing
Partner Counseling Referral Services

MSM/IDUs
Syringe Exchange/Outreach
Individual Level Interventions
Partner Counseling Referral Services
Counseling and Testing
Prevention Case Management

IDUs
Outreach Syringe Exchange Program
Counseling and Testing
Partner Counseling Referral Services
Individual Level Interventions

Transgender at Risk
Counseling and Testing
Prevention Case Management
Partner Counseling Referral Services
Individual Level Interventions
Outreach

Women at Risk
Outreach
Counseling and Testing
Individual Level Interventions
Prevention Case Management
PCRS

B. Needs Assessments

The Needs Assessment and Evaluation Committee was a part of the former HIV Prevention CPG. It was comprised of CPG members. Based on the recommendations from the Hawai`i CPG over the years, various needs assessments have been produced. These needs assessments have included HIV prevention-related questions on priority populations. Needs assessments have been developed for these at-risk populations:

- Asian Pacific Islander men who identify as gay or bisexual (1999)
- HIV+ Persons (2001)
- MSM/IDUs (2001)
- Women at Risk (2001)
- Latino/as at Risk on Maui (2001)
- African Americans at Risk on O`ahu (2003)
- IDUs (2004 CHOW SEP Evaluation Report)
- Transgender individuals (2005)

The CPG uses the information and recommendations from needs assessments to help determine prevention needs for these populations. This information then is discussed related to strategies and interventions for each of the prioritized populations.
The following is a compilation of all the recommendations resulting from needs assessments in Hawai`i for each of the priority populations:

! **Asian & Pacific Islander men who identify as gay or bisexual**
Recommendations:

- Increase recruitment, training and visibility of positive role models who are API, "local" (born and raised in the islands), gay men and able to accept the dual roles of being gay identified as well as tied to their local roots and traditions.
- Use approaches that demonstrate the ways API – and other men of color-- can learn to manage competing social roles, identity development, and healthy behavior regarding sexuality, race/ethnicity, and gender in a uniquely "local" Hawaiian way.
- Develop culturally based messages that are specific to Hawaii's racial/ethnic, class, historical and "local" community.
- Increase outreach at public sex environments (PSEs) and increase other types of HIV prevention to API, possibly using "natural leaders" who are bisexual and not necessarily "publicly" gay-identified.
- Design dual purpose HIV/AIDS and social support programs to help negotiate the barriers of social stigma and geographical isolation for many API gay men, especially outside the Honolulu area.
- Develop cooperative funding proposals to enhance collaboration between HIV/AIDS, racial/ethnic, LGBT, arts and other culturally relevant organizations.
- Support the extensive use of Orasure testing in appropriate settings in order to increase the number of people at risk who know their HIV status

· Increase the number of interventions aimed at younger people in lower “stages of change” to bring them to the “maintenance” stage. Continue with “maintenance” stage interventions to encourage those in the “maintenance” stage to remain in that stage.

2. HIV Positive Persons (P4P = Prevention for Positives)

Based on a recommendation from the CPG in 2000, the SAPB in 2001 contracted to develop recommendations for the design and implementation of interventions for reducing HIV-infected persons' risks of transmitting HIV to others. The 2001-2002 Hawai`i PHIP Needs Assessment, completed in April 2002 provided the CPG and Hawai`i CARES with the foundation for their recommendations for the direction of primary prevention services for individuals living with HIV (P4P/PHIP) and linkages with secondary prevention as well. These recommendations led to the creation of a statewide P4P/PHIP Coordinator's position as well as P4P/PHIP positions at each of the contracted CBOs for provision of services to this population. These positions cover all counties in Hawai`i. They have been staffed since mid-2003 and will continue in 2004 and beyond. Training and technical assistance have been introduced and are offered on an ongoing basis to develop skills to work effectively with this priority population. The SAPB contracts will continue to have a significant emphasis on P4P services. The CPG and Hawai`i CARES will continue to evaluate these services. Issues and concerns that are generated from these evaluations will be shared with the CPG and will shape the future course of services for primary prevention for HIV-infected persons. In 2004 the statewide coordinator developed a work plan for the implementation of the program. Highlights from work plan objectives include:

Recommendations:

- Increase individual level interventions with people living with HIV and their sex and needle-sharing partners.
- Build skills and experience in coordinators to provide confidential and non-judgmental support through trusted relationships.
- Expand PCRS services beyond newly HIV diagnosed clients to ongoing support.
- Ensure that ongoing support around disclosure is available to sexually active people living with HIV.
- Increase referrals from physicians, clinicians, community health centers and other agencies to the P4P program.

This work plan has been distributed statewide to contracted agencies and is being used to further develop the program. Objectives outlined in the plan will be monitored and reviewed to provide ongoing definition to the program.

3. MSM/IDUs

Recommendations:

! Continue to have agencies serving MSM/IDU, such as the Syringe Exchange Program (SEP), provide easily accessible services. Because MSM/IDUs are hard to reach and often hidden, single service HIV intervention programs that target IDUs and MSM must work together in coordinated prevention efforts.

! Develop individualized interventions (such as Prevention Case Management) to address the specific circumstances of the varied lives and risk behaviors of MSM/IDUs.

! Educate agencies serving MSM/IDUs of their clients’ special needs regarding drug use, HIV risk and mental health, financial and living situations. Training for social service providers must sensitize them to the dual stigma that clients face.

In-service training should include components making MSM-oriented services friendlier to IDUs and IDU-oriented services friendlier to MSM.

- Include discussion of MSM/IDUs in primary prevention services for HIV positive persons. Over one-third of the MSM/IDUs interviewed were HIV positive persons and reported not always using condoms with their sexual partners.
- Address the serious mental health needs of MSM/IDUs. Mental health service providers need to be aware of the stigmas and circumstances faced by these individuals. For some MSM/IDUs, it may not be possible to make much progress with other issues unless their mental health needs are dealt with.
- Provide more education on safer shooting practices

4. Women at Risk

Recommendations:

- Support primary prevention for HIV positive men with a focus on risk to women partners.
- Actively provide outreach to MSM/IDUs and IDUs who share needles with women.
- Encourage and support HIV prevention with other populations of men with possible high HIV risk and with their female partners.
- Support women-centered health and/or social services on each island that integrate HIV prevention.
- Encourage collaboration between ASOs and women-based agencies.
- Conduct HIV prevention for women whose male partners are in known risk categories.
- Encourage earlier counseling and testing for women at risk.
- Develop HIV prevention programs for women with a focus on poorer and younger women and women of color.
- Encourage and support more and better women-center substance use services.
- Offer counseling for couples where women have partners who are HIV positive or at risk for HIV.
- Strongly support needle exchange.
- Encourage efforts to lessen stigma related to HIV, bisexual behavior and drug use.

5. Latinos at Risk

Recommendations:

- Prevention programs for MSM in this population must take into account the phenomenon of non-gay identified MSM identity.
- The Latino culture's connection to church and family must be considered when developing prevention programs for at-risk populations in this community.
- HIV prevention messages directed towards the at-risk Latino community must take into account language, national origin and culture.
- The use of culturally appropriate outreach educators must be utilized when providing HIV prevention education and services to at-risk populations in the Latino community.
- Increase awareness and make available culturally appropriate information about Hawai`i needle exchange program and HIV prevention information.
- Information and access to HIV counseling and testing must take into account the

Latino culture, including providing culturally appropriate counselor/testers for the provision of service.

6. African Americans at Risk

A process to facilitate a needs assessment regarding African Americans at risk for HIV in Hawai`i was initiated in 2001. After several preliminary efforts, including a preliminary report to provide direction for this needs assessment, the final needs assessment report was completed and presented to the CPG and the SAPB in February 2004. Its recommendations were related to African Americans on O`ahu at highest risk for HIV: *MSM, IDU, and women at risk.*

The recommendations supported by this report are:

Continued efforts be made to increase the communication and collaboration between the Hawai`i Department of Health and its service partners with African American organizations and stakeholders to provide effective and culturally relevant HIV/AIDS prevention services to African Americans in Hawai`i.

- Researchers and service providers need a better understanding of the role of cultural and socioeconomic factors in the transmission of HIV among African Americans, as well as the effect of the history of racial inequality on public health.
- Targeted strategies must be designed and implemented for young African Americans at risk for HIV/AIDS
- Increased and specific services targeted to reach African American women should be designed and implemented in Hawai`i
- Public health officials should consider changing epidemiological surveillance to include other demographic information such as social, economic and cultural factors.
- Public health institutions should seek out partnerships with African American faith communities and incorporate spiritual teachings on compassion to ignite a community response.
- Comprehensive HIV programs should link with other health services, such as substance abuse programs, family planning services and STD clinics

7. Transgenders at Risk

In July 2004, based on the recommendation of the CPG Needs Assessment Committee, the SAPB contracted with a PhD-level professor from California State University at Chico to implement the "HIV Risk and Prevention Needs of Male-to-Female Transgendered Persons in Hawai`i". She collaborated with community-based organizations in Hawai`i to administer written surveys, one-on-one interviews and focus groups to determine the needs of transgender individuals at risk for HIV in Hawai`i.

This study collected data and statistics regarding health status and access to preventive services for transgender people in Hawai`i. The findings from the study were used to prioritize the transgender group among populations at risk and to determine interventions for this at-risk population.

The report of these needs assessment activities was completed and presented to the CPG in early 2005.

The recommendations from this needs assessment are:

1. Continue and expand public and organizational education about transgender people.

2. Continue and expand education and programs within the TG community (using TG role models) that reduce the likelihood of SIW and drug selling for economic survival: community building events, high school diploma completion and grants for high education, job training, interview skills, support groups.

3. Continue and expand outreach efforts (education, referral, condom distribution and HIV testing) to SIW in Honolulu and in other areas of O`ahu.

4. Continue and expand targeted outreach and education to younger TGs – HIV and drug use prevention and recovery, job training, high school completion and higher education.

5. Continue and expand support for existing and additional TG-only transitional housing for drug recovery, homelessness, and HIV-positive TGs.

8. Injection Drug Users

Hawai`i was the first state in the country to have a statewide and state-funded syringe exchange program (SEP). Hawai`i's SEP began in 1990 has been operated by the non-profit Community Health Outreach Work (CHOW) Project since 1993. The CHOW project conducts a detailed and thorough annual evaluation of its services in collaboration with their evaluator, Dr. Don DesJarlais from Beth Israel Medical Center in New York City. This evaluation represents an annual needs assessment of active injection drug users in Hawai`i and the CPG utilizes this annual evaluation as such and has not recommended a separate needs assessment of IDUs in Hawai`i. The latest evaluation titled "Hawai`i Statewide Syringe Exchange Program 2004 Evaluation Report" has the following recommendations.

Recommendations:

- The SEP program has grown substantially over the last several years and the highest priority should be given to maintaining the quantity and quality of SEP services.
- There are many advantages to providing services from a fixed site and this option should be explored. Any fixed site should be convenient for SEP clients while maintaining the services of the mobile exchange.
- Collaboration with mental health agencies is needed to link the IDU population to mental health services. The existing successful collaboration between The CHOW Project and the Department of Health to bring HIV counseling and testing services to clients should be continued and strengthened by regular scheduling of HIV C&T on all SEP mobile routes. The CHOW Project should refer IDUs to DOH for hepatitis A and B vaccinations and hepatitis C counseling and testing. The SEP should continue to collaborate DOH and other community agencies to implement the statewide Hepatitis C Strategic Plan.
- Explore the possibilities of providing broader services to IDUs either directly or through organizational linkages with other programs.
- Methadone treatment services should be continued on O`ahu, Maui and E. Hawai`i and should be expanded to W. Hawai`i and Kaua`i.
- Every effort should be made to increase the availability of sterile injection equipment for IDUS and the SEP should continue to monitor pharmacy purchased syringes, especially regarding difficulty in obtaining syringes.
- IDUs should have ready access to screening and treatment for STDs. The CHOW Project staff should provide continual STD education and referral information to participants.
- In conjunction with the P4P program, the SEP should work to ensure that those

IDUs who test positive for HIV have sufficient access to a full range of prevention services, including syringes and condoms.

- The HIV sero-prevalence study conducted this year provides the first estimate of HIV infection among SEP clients and it would be desirable to repeat this study in the coming year.

IV. Technical Assistance for CPG Members

The Steering Committee plans orientation, training, and TA events for the CPG. Because this is a newly organized group that addresses care, prevention and "overlap" issues, education and training is particularly important so that members are well versed in the issues at hand. Two full days of Orientation were therefore conducted before the first business meeting was undertaken. At each monthly meeting, the orientation has been continued in the form of educational presentations, discussions, and interactive exercises. Presentations may be conducted by "outside" experts, DOH staff, or by CPG peers.

In the future and interest and needs assessment will be carried out to gauge CPG member needs and interests for TA in 2006. Finally, the two new CPG community co-chairs were sponsored to attend the "HPLS" meeting in San Francisco in August 2005.

V. Program Evaluation Process

During 2006, HIV prevention programmatic evaluation will continue to be centered at implementation of the Program Evaluation and Monitoring System (PEMS). The PEMS is a comprehensive confidential data collection system developed by the CDC. This web-based software and data collection/reporting system supports standardized data collection, reporting, analysis, and delivery of HIV prevention programs. Transition to the PEMS marks not only a major change in the types of data collected and data collection methods, but also a major paradigm shift in the HIV prevention interventions and how they are implemented and evaluated. The PEMS serves as the data collection/reporting tool to support implementation and evaluation of the Diffusion of Effective Behavioral Interventions (DEBI) and other evidence-based intervention approaches, including outreach as well as individual-level (ILI), group-level (GLI), and community-level interventions (CLI). Specifically, the PEMS provides a foundation for data collection and reporting related to: 1) agency and contracted agency information, including budgeting; 2) program/intervention level data; 3) client/intervention level; 4) community planning; 5) Counseling and Testing (C/T); 6) Partner Counseling and Referral System (PCRS).

In close collaboration with the CDC, the DOH STD/AIDS Prevention Branch will continue providing leadership and full deployment support to assist the DOH and CBO staff to fully transition to using the PEMS. Specifically, significant ongoing training and support will continue addressing: 1) collection and reporting of the PEMS data; 2) use of the PEMS to provide feedback data for program monitoring and improved capacity; 3) collection of client-level data to help programs increase the number of HIV-infected individuals who know they are infected; 4) use of the PEMS tracking and referral capabilities to increase the proportion of HIV-infected individuals who are linked to services; and 5) assessment and analysis of data collected through the PEMS so programs can use the data to decrease the number of people at risk for HIV.

VI. Linkages and Cross Program Activities

$ Sexually Transmitted Diseases

HIV and STD prevention are structurally integrated in the STD/AIDS Prevention Branch (SAPB). DOH staffs at the Diamond Head STD/HIV Clinic and the neighbor island HIV counselor/testers continue to receive cross training and updates in both program areas. Overall there is concern regarding the increases in all STDs in recent years and particularly around co-infection with HIV among specific risk populations including MSM. This latter aspect overlaps with the P4P activities. Overall, the DOH is attempting to implement the new CDC STD treatment guidelines. This is particularly true regarding the annual STD screening of sexually active MSM. The Diamond Head clinic ensures that all MSM testing for HIV are also offered a full STD examination or syphilis screening at the minimum. Neighbor Island counselors/testers will also continue to offer syphilis screening to sexually active MSM/high risk individuals testing for HIV. SAPB hopes to have urine-based gonorrhea and chlamydia testing available for use by neighbor island counselor/testers in the latter part of 2005. While this will be an important adjunct service it provides results for site-specific infections and may not identify some MSM STD infections. A proposal to allow HIV counselor/testers to provide medication for patients diagnosed with CT and possibly GC. Expedited partner therapy is under consideration but would require changes in the law to be implemented. A referral protocol to treating physicians is being developed, particularly for those without insurance. Initially it is proposed that services would be covered by DOH for a community clinic and a private provider in each area. Demographic information on clients with STDs should be used increasingly to target sub-populations within risk groups for prevention follow-up.

SAPB offers annual complete syphilis testing for HSPAMM's more than 850 HIV+ clients. This is a significant percentage of the total Hawai`i HIV+ population and will provide screening for this population and additional information for P4P service providers.
Hawai`i has seen a dramatic increase in drug resistant gonorrhea in all risk populations. This is important information for all treating physicians. Internally, STD and HIV staff also continue to have regular staff meetings to discuss common issues and concerns.

B. Viral Hepatitis Education and Prevention Program

The CDC-funded Hepatitis C Coordinator position has been situated within SAPB since June 2002 and coordinates SAPB's Viral Hepatitis Education and Prevention (VHEP) program. The Hepatitis C Coordinator's role is to support the integration of viral hepatitis into existing HIV, STD and other related programs and to enhance collaborations to address the needs of adults who are at-risk for and living with viral hepatitis in Hawai`i. In 2003, a Hepatitis C Strategic Plan was created with key stakeholders to identify hepatitis-related goals and objectives for Hawai`i. SAPB is currently implementing the plan with an update scheduled for early 2006. VHEP activities include providing viral hepatitis information, education and training to health and social service providers and other community members, as well as collaborating with other sections of DOH and community-based agencies to raise awareness about viral hepatitis. Currently, all SAPB HIV counseling and testing sites offer viral hepatitis education, hepatitis A and B immunizations and hepatitis C testing and counseling. All SAPB contracted agencies are required to integrate viral hepatitis education and referrals into their HIV prevention services and in late 2005, SAPB contracted agencies will be able to offer hepatitis C screening with their HIV counseling and testing services.

C. Tuberculosis
The SAPB and the TB Branch are both part of the Communicable Disease Division and meet at least once a month to discuss common issues. SAPB staff have provided training to TB clinic staff so they can directly provide HIV counseling and testing services to individuals testing positive for TB. The TB Branch requested to have confidential HIV testing so that the results can be used for diagnostic and treatment purposes by the TB Branch physicians. The SAPB will remain responsible for the overall quality assurance for this service. Fortunately, HIV and TB currently remain in separate populations in Hawai`i with very low co-morbidity. TB staff will offer sufficient counseling to meet informed consent requirements and provide negative results while SAPB staff will provide counseling for any patients that test HIV positive. Unfortunately, the TB program has not yet started doing HIV testing. SAPB will continue to collaborate with the TB program to encourage it to get this critical service underway.

D. Substance Use Treatment
The SAPB remains an important player in this field, because it has a state funded contract with the CHOW Project (which operates the sterile syringe exchange program) to subcontract for methadone services for clients referred by the needle exchange program. Methadone treatment services are now available on O`ahu, Maui and the Big Island. LAAM, a longer lasting treatment modality is no longer available so this makes treatment more difficult for individuals in rural areas who have to travel to the clinic for treatment more frequently than when they were on LAAM. A representative of the Alcohol and Drug Abuse Division (ADAD), a pharmacist and a staff member dealing substance abuse and treatment of native Hawaiians serve as members of the Syringe Exchange Oversight Committee. The SAPB will continue to provide HIV counseling/testing training, support and supervision for ADAD's contracted EIS providers throughout the state. Their testing data are provided to the SAPB for inclusion in our anonymous test site data. SAPB is coordinating with ADAD around the SAMHSA HIV rapid testing initiative. When the State Administrative Rules are changes to allow for waived tests then the collaboration should increase access to HIV testing for individuals in substance abuse programs.

E. Corrections
The State of Hawai`i Corrections Medical Director joined the CPG in mid-2003. The SAPB will continue to provide HIV counseling and testing services in correctional facilities throughout the state. STD and HIV testing and prevention services will continue to be provided to juvenile offenders on O`ahu. This service will be expanded in additional facilities. The SAPB's HSPAMM program can continue to offer medical and laboratory services to inmates and assist them to get into or remain in medical care upon release. This is part of our collaborative approach to providing primary prevention services to HIV positive inmates.

The Hawai`i Corrections Medical Director will continue to be part of HIV planning process in Hawai`i, as she is the appointed representative for Corrections on the new combined prevention and care CPG.

F. HIV Care and Treatment
The SAPB is the grantee for funding from both CDC prevention and HRSA Ryan White Title II for care. This provides for integrated service planning and implementation within one administrative branch. Both state and federally funded contracts with CBOs now focus increasingly on providing a spectrum of care and prevention services. In most geographic areas, both services are provided by the same ASO.

One of the important tasks of the HIV counseling and testing trainer is to strengthen referral and tracking of individuals from counseling and testing into care and support services. With continuing HIV reporting, which started in September 2001, there are increasing opportunities for tracking linkages and referral services.

In early 2004 a Joint Planning Committee, made up of members of the CPG and Hawai`i CARES, began working on the issue of collaboration and unification of the two planning bodies. No workable conclusion was reached initially. However, a new group continued to meet and produced recommendations in the last quarter of 2004. Major objectives are to strengthen prevention/care collaboration and to link services in planning, program implementation at the client level. The increased focus on prevention for positives is a central aspect of the continuum of prevention/care services needed. The newly formed, combined CPG began business in March 2005.

G. Department of Education

A representative from the statewide DOE is appointed to and serves on the CPG. A number of CPG members and SAPB staff sit on advisory committees established by DOE around matters related to sexual minority youth, sexually transmitted diseases, and health education. DOE's policy to prohibit discrimination and harassment related to individual status, including minority sexual status, is currently being addressed by DOE. The SAPB Prevention Coordinator serves on the committee charged with implementing these new policies. The Prevention Coordinator is also a member of DOE's Comprehensive School Health Program collaboration group. The objective of this group is to initiate state infrastructure support for CSHP development and implementation at the school level. The Prevention Coordinator will continue to meet with the DOE administration about issues related to HIV/STD prevention and school-aged youth.

H. Primary HIV Prevention (P4P)

The joint Hawai`i HIV/AIDS CPG will participate in reviewing and refining recommendations on the provision of primary prevention services for people living with HIV (P4P) and linkage with secondary prevention. Recommendations will largely be based on the *2001-02 Hawai`i P4P Needs Assessment* completed in April 2002 by contractors of the SAPB as well as the 2004 P4P work plan. Both documents have been shared widely within the overall community and with provider agencies. THE SAPB prevention contracts that begin in 2003 and are continuing have a significant emphasis on P4P services. SAPB and its contracted agencies have all hired P4P Coordinators and will continue to provide services. All are trained in HIV counseling and testing and have had significant training in STD and hepatitis. The recently developed P4P work plan also includes increased collaborative efforts with outreach to physicians. Therefore, medical providers can increase and improve their prevention activities and make better use of P4P resources.

VII. Innovative Projects

A. Hepatitis C Testing and Counseling at SAPB Contracted Agencies

In 2004, SAPB implemented a successful hepatitis C counseling and testing pilot project at all SAPB HIV/STD counseling and testing sites on O`ahu and the neighbor islands. SAPB will support contracted agencies in integrating hepatitis C counseling and testing into their HIV counseling and testing services starting September 1, 2005. SAPB contracted agencies will receive hepatitis C testing kits, educational materials, training and technical assistance to support the hepatitis C counseling and testing program. All state-certified HIV counselors and testers are already trained to integrate viral hepatitis education and referrals into HIV counseling and testing.

B. Methamphetamine Use and Impact on Sexual Health, HIV, STDs and Viral Hepatitis
In June 2005, the SAPB sponsored a community forum at the Pacific Global Health Conference titled "Sexual Health for Methamphetamine Users" to begin a community dialogue about the impact of methamphetamine use in Hawai`i as well as the effects on risks for HIV, STDs and viral hepatitis. The forum was well received and will inform SAPB's on-going efforts in 2005 to address the STD, HIV and viral hepatitis related impact of methamphetamine use in Hawai`i.

C. Counseling and Testing (CT) Data Collection Pilot
In 2005 Hawai`i joined two other states (Utah and Nebraska) as CDC's Pilot Sites for beta-testing a novel approach to CT data collection and submission. CT data constitute one of the major building blocks of the Program Evaluation and Monitoring System (PEMS), a novel comprehensive, confidential data collection tool developed by CDC for nation-wide use to support implementation and evaluation of HIV prevention programs. The new CT data collection methodology is designed to significantly streamline collection and submission of the CT data. The CT Data Collection Pilot involves a close collaboration between HIV counselors and testers statewide, SAPB, and the CDC.

D. Implementation of Evidence-based Interventions:

A re-prioritization of HIV prevention interventions was completed by the CPG in early 2005. SAPB staff have provided trainings related to evidence-based intervention to be implemented based on the results of this re-prioritization process. These trainings have emphasized the availability of resources for evidence-based interventions, including CDC's DEBI and REP+ programs. The potential impact of these trainings and emphasis on evidence-based interventions is more effective HIV prevention services available to at-risk groups in the community.

VIII. APPENDICES

APPENDIX A
The Kakou Model

Kakou ("We, together")

Community Planning for HIV Care and Prevention in Hawai`i

Recommendations

I. History and Process of the *Kakou* group

The Kakou planning task force was formed in May 2004. It was charged by the STD/AIDS Prevention Branch Chief to come up with recommendations concerning the mission, goals and objectives, organizational structure, membership eligibility and basic implementation steps for a collaborative community planning process for prevention and care services in Hawai`i. The SAPB Branch Chief also gave the group five essential parameters that had to be included in the outcomes of the Kakou's product. These five parameters are- (not necessarily in priority order):

1) Save costs
2) Build on strengths of Hawaii's community planning (PIR*; Minority and consumer participation)
3) Support continuum of HIV prevention and care services
4) Allow access of key stakeholders
5) Meet planning objectives.

Membership of Kakou initially consisted of five members of the CPG and five members of HI CARES. Two staff from SAPB provided facilitation and support.
The Kakou met six times: June 7, June 30, July 12, July 26, August 25, and September 13, 2004.
The recommendations in the document are the product of those meetings.
This document will be shared with the CPG and HI CARES. CPG and HI CARES members are welcomed to add any feedback or additional ideas to this document in written form. Any written comments from the CPG and/or HI Cares will then be attached to this document and forwarded to the SAPB Chief for consideration.

* **PIR** is a requirement of CDC's Guidance for Community Planning Groups. PIR stands for *Parity, Inclusion and Representation. Parity* is defined as the ability of members to equally participate and carry out planning tasks/duties. *Inclusion* is defined as meaningful involvement of members in the process with an active voice in decision-making. *Representation* is defined as the act of serving as an official member reflecting the perspective of a specific community. To guarantee PIR, the Kakou recommends that *at least 50%* of the membership be composed of consumers and at-risk people.

II. Recommendations

A. Rationale for a Joint, Collaborative Planning Group

One of the major reasons for having closer collaboration between care and prevention planning is to ensure a continuum of services based on the needs in the community rather than on the dictates of the two separate federal funding streams. There are increasing overlaps in target groups and services that could use better coordination; for example, the new emphasis on prevention services for HIV+ individuals as well as the need for coordination of traditional case management with prevention case management. There are opportunities for linkages between care and prevention that would not be likely to occur without collaborative planning. There is the potential for improving needs assessments, community resource inventories, gap analyses and evaluations.

With flat and decreased funding for all services expected in the future, it is important to make the most efficient use of resources. Some resources can be saved from not having to support two quite separate planning groups. Costs for logistics can be reduced and more efficient use of SAPB staff can be achieved.

Both HRSA and CDC have been encouraging jurisdictions around the country to explore collaborative planning. To date, a number of jurisdictions have already taken the plunge and others are in the process of doing so. Hawai`i, in particular, is a good candidate for the new model because of its relatively small size and wealth of existing relationships in the HIV/AIDS community. Nevertheless, the proven strengths of the two existing groups, the CPG and HI CARES, should not be lost. A major strength has been the groups' abilities to represent the diversity of various communities in the state, including those who have been traditionally underserved, marginalized and disempowered.

Representation of these groups must continue, and in numbers where their voices will truly be able to be heard at the table. Hence, the numbers of recommended members noted in sections E, E1a, and E1b of this document (below) should be seen as minimum numbers of members, rather than the ideal.
This document is meant as the beginning to point the way towards this new model.

B. Mission Statement

The Kakou group developed this mission statement:
To implement a community-based, integrated planning process for Care and Prevention services for all persons at risk and for all affected / infected by HIV/AIDS in Hawai`i.

C. Goals and Objectives

The Hawai`i HIV/AIDS Planning Group will, in addition to the goals and objectives listed below, follow any relevant guidelines set forth by CDC and HRSA.

Goal 1
Support broad-based community participation in HIV/AIDS prevention and care planning.

Objective A
Foster a community planning process that ensures parity, inclusion, and representation (PIR) among planning members.

Objective B
Ensure that the membership is representative of the diversity of populations most at risk for HIV infection and those affected and infected by HIV/AIDS and includes professional expertise and representation from key governmental and non-governmental organizations in the community.

Objective C
Implement an open recruitment and selection process for community membership.

Goal 2
Identify priorities for HIV/AIDS prevention and care needs.

Objective D
Carry out a logical, evidence and science-based process to determine priorities for 1) care services and 2) populations at risk and strategies/interventions for prevention services.

Goal 3
Advocate that resources for HIV/AIDS prevention and care services target priorities identified in the Hawai`i Comprehensive HIV/AIDS Care-Prevention Plan.

Objective E
Ensure HIV/AIDS prevention services funded by DOH accurately reflect the needs of the prioritized populations at risk and the strategies and interventions prioritized in the Comprehensive HIV/AIDS Care-

Prevention Plan and the Interim Progress Report (Application) submitted to CDC.

Objective F

Ensure HIV/AIDS care services funded by DOH accurately reflect needed services identified as high priorities in the Comprehensive HIV/ AIDS Care-Prevention Plan.

Goal 4

Ensure that a periodic *Comprehensive HIV/AIDS Care-Prevention Plan* recommends which prioritized services are delivered in the community.

Objective G

The Plan lists goals to achieve a comprehensive continuum of prevention and care services, an action plan to help reach those goals, and an evaluation component.

D. The Organizational Model

Considerable time was spent by the Kakou members to develop a structure and organization that would function well to get the various care and prevention planning tasks done in an efficient and cost-effective manner. This became known as choosing "the model." Other models from other states and jurisdictions were researched, studied, and compared by the Kakou members. Some were clearly inappropriate or irrelevant to the needs of the state of Hawai`i. There were, however, parts of other models that were helpful and relevant. After a number of draft models were discussed, the following unique model was decided upon to recommend:

Leadership:

It is recommended that there be three (3) Co-chairs of the planning group: 1) one who is a staff person of the SAPB, DOH, who is well versed and has had experience in both care and prevention issues, 2) one Community Co-chair should be well versed in care service issues and be familiar with prevention, and 3) one Community Co-chair should be well versed in prevention issues and be familiar with care services. The three Co-chairs and the Chairs of the four (4) standing committees will make up the Steering Committee.

The three Co-chairs will provide overall direction of the planning group, facilitate the general meetings, and ensure that the annual work plan is being accomplished appropriately and in a timely manner.

Meetings:

It is recommended that the planning group have eight to nine (8-9) meetings per year help ensure continuity and effectiveness of the new planning group.

Committees:

In this model, most of the detailed work of the planning group will be accomplished at the committee level. It is recommended that there be four (4) permanent standing committees. In addition, a number of ad hoc, temporary committees may be established for specific tasks for short periods of time as needed. It is anticipated that committees will meet for sufficient time (approximately 2 hours) during the regular day-long meetings of the planning group. In

this way, benefits are achieved: the maximum amount of participation from members can be achieved and the committees can report back to the larger group about their progress and get any needed advice and feedback promptly. The Steering Committee may have to meet at a separate time from the four standing committees.

E. Membership of the Planning Group:

The comprehensive HIV services planning group should be composed of approximately twenty-eight (28) members. Not less than fourteen (14) of these members shall represent consumers/persons-at-risk. Not more than an equal number of individuals representing HIV service providers, appointed members, and the STD/AIDS Prevention Branch shall also serve on the planning group.

1. Consumers/Persons-At-Risk

There should be not less than fourteen (14) consumers/persons-at-risk on the planning group. These members shall be selected from the following HIV-affected groups:

- HIV-positive;
- MSM;
- IDU/MSM/IDU;
- TG;
- Women.

While these HIV-affected groups represent the at-risk populations that were prioritized by the CPG to be the focus of prevention efforts, they also represent the range of individuals who are involved in the HIV care services planning process. Selecting planning group members from this range of HIV-affected groups would maintain parity, inclusion, and representation.
In addition to these six (5) groups listed above, these members shall also be drawn from the following two (2) groups:

- special populations (including, but not limited to, individuals who are dual-diagnosed, Native Hawaiians, substance users, commercial sex workers, individuals who are homeless); and
- at large.

1 a.) HIV-Positive

Of the fourteen (14) total consumers/persons-at risk members, seven (7) or 50% of these members **must** be individuals who are HIV-positive. These individuals must be able to present the perspective of consumers of HIV care services. These seven (7) HIV-positive individuals shall be selected in the following manner:

- two (2) shall be MSM;
- one shall be IDU or MSM/IDU;
- one shall be a TG;
- one shall be a woman;
- one shall be from a special population; and
- one shall be at-large.

Every effort shall be made to select an HIV-positive individual or individuals from each HIV-affected group. However, in the event that a suitable HIV-positive individual cannot be found, an individual who can reasonably present the interests of that HIV-affected group may serve on

the planning group; i.e., a former member of that HIV-affected group; staff from an agency that provides services to that HIV-affected group, etc.

1 b.) At-Risk Populations

Of the fourteen (14) total consumer/persons-at-risk members, seven (7) members **must** be individuals who are from the at-risk populations that have been prioritized by the CPG to be the focus of prevention efforts. These members representing at-risk populations may or may not be HIV-positive. They must, however, be able to present the interests of the at-risk populations in regards to receiving prevention services.

These seven (7) individuals from the at-risk populations shall be selected in the following manner:

- two (2) shall be MSM;
- one shall be IDU or MSM/IDU;
- one shall be a TG;
- one shall be a woman;
- one shall be from a special population; and
- one shall be at-large.

In the event that a suitable member from an at-risk population cannot be found, an individual who can reasonably represent the interests of that at-risk population may serve on the planning group; i.e., a former member of that at-risk population; staff from an agency that provides services specifically to that at-risk population, etc.

In addition to seeking members who are from the HIV-affected groups, who are HIV-positive, and who are from an at-risk population, the following considerations should be taken into account when selecting these members to serve on the planning group:

- geographic representation: a minimum of one person from each of the major geographic areas served by STD/AIDS Prevention Branch contractors, providing both care services and prevention services, must be on the planning group;

- ethnicity: minority groups disproportionately affected by the epidemic must be represented on the planning group (e.g., African-Americans, Native Hawaiians);

- income levels: individuals who are eligible to receive Ryan White CARE Act services, i.e. individuals who meet the income criteria, and individuals who are unable to afford adequate shelter should be members of the planning group;

- gender representation: the planning group must include males, females, and transgender individuals;

- age groups: the planning group should include representation by individuals, both males and females, who are: 14-24 years of age, 25-49 years of age, over 50 years of age.

2. Service Providers

The number of planning group members who represent service providers may be equal to but not more than the number of consumers/persons-at-risk. Planning group members who represent service providers should be individuals from agencies who provide the following HIV/AIDS services:

- case management (care case management and prevention case management);
- housing (emergency/short term, long term, transitional);
- mental health;
- outreach;
- counseling and testing;
- syringe exchange;
- substance use;
- Medicaid Waiver Program;
- nutritional counseling;
- primary medical care;
- dental;
- behavioral intervention;
- legal advocacy;
- pharmacy; and
- at-large.

3. Appointed Members

The planning group members representing service providers should also include individuals **appointed** to specifically represent the following programs:

- Department of Education;
- Corrections Division, Department of Public Safety;
- Ryan White Consortium;
- STD/AIDS Prevention Branch, Department of Health;
- HSPAMM, H-DAP, H-COBRA and
- Medicaid Waiver Program.

In addition to seeking members from HIV service providers and from appointed members, the following considerations should be taken into account when selecting service providers to serve on the planning group:

- geographic representation: service provider members of the planning group should be drawn from each of the major geographic areas served by STD/AIDS Prevention Branch contractors, both care services contractors and prevention services contractors;

- prevention and care services: the service provider members of the planning group should reflect a balanced representation of care and prevention services;

- multiple service providers: where possible, agencies/programs that provide more than one service should be considered, e.g. AIDS service organizations;

- community health centers: representation from community health centers should be sought.

F. Next Steps and Tasks to be completed before Implementation

Assuming that these recommendations are accepted essentially as proposed, a number of specific tasks need to be planned and implemented before the new planning group will be able to have its first business meeting in 2005.
The Kakou was not charged with recommending the details of the implementation steps or process; however, at the last Kakou meeting, DOH staff shared a draft list of tasks that need to be done with a rough timeline for implementation.

APPENDIX B

List of Abbreviations:

ACCT	*AIDS Community Care Team*
ADAD	*Alcohol and Drug Abuse Division*
AED	*Academy for Educational Development*
API	*Asian and Pacific Islander*
ASO	*AIDS service organization (a community-based organization)*
ATS	*Alternative testing sites*
CAC	*Community advisory committee*
CAG	*Community advisory group*
CBO	*Community-based organization*
CDC	*Centers for Disease Control and Prevention*
CHOW	*Community Health Outreach Work Project (needle exchange services statewide)*
CLIA	Clinical Laboratory Improvement Act
CLI	Community Level Intervention
CPG	Community Planning Group
CT or C/T	Counseling and testing
CTS	Counseling and Testing Sites
CTR	Counseling, Testing and Referral

DASH	Drug Addiction Services of Hawai#i
DIS	Disease intervention specialist
DOH	Hawai#i Department of Health
EIS	Early Intervention Services
"Epi"	Epidemiologic
GayMAP	Gay Men's AIDS Prevention
GCHA	Governor's Committee on HIV/AIDS
GLI	Group Level Intervention
HC/PI	Health Communication / Public Information
H-COBRA	The H-COBRA program assists people to retain health insurance after they have left employment due to HIV.
HDAP	HIV Drug Assistance Program
HSPAMM	Hawai`i Seropositivity and Medical Management Program[1]
IDU	Injection drug user
ILI	Individual-level intervention
LGBT	Lesbian, Gay, Bisexual, Transgender
MSM	Men who have sex with men
NGI MSM	Non-gay-identified men who have sex with men
OCCC	O`ahu Community Correctional Center
OSHA	Occupational Safety and Health Act
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
P4P	Prevention for Positives
RFP	Request for Proposal
SAPB	STD/AIDS Prevention Branch of the Hawai`i Department of Health
SEP	Syringe Exchange Program
STD	Sexually Transmitted Disease
TG	Transgender, transgendered
UH	University of Hawai`i

The state-funded **HSPAMM** program provides, through participating providers, a history, physical, and immune function tests every six months to individuals with HIV. The person with HIV is monitored throughout the course of the infection and the physician can intervene early to minimize viral replication and prevent opportunistic infections, thereby prolonging and enhancing quality of life. The **HDAP** program provides HIV treatment drugs to eligible individuals.